

Gallatin Mental Health Center

Bozeman, Montana

March 19-20,
2015

Montana Disabilities Board of
Visitors Site Inspection Report

Summary

On March 19 and 20, 2015, the Mental Disabilities Board of Visitors (BOV) conducted a site inspection of Gallatin Mental Health GMHC (GMHC), pursuant to Section 53-21-104 Montana Codes Annotated (MCA).

The site inspectors were overwhelmingly impressed by the quality of service delivery, the physical plant, the available services, and the treatment philosophy of the staff at GMHC. GMHC treatment approach is recovery-based, focusing on client strengths, and fosters independence and autonomy among clients. Staff and clients alike were positive in their comments about the program and its services. One staff person said, "I love working here. It's been one of my most rewarding jobs." Clients likewise stated they felt "valued" that staff is "awesome" and clients are "growing with [their] support."

Overall the GMHC leadership and staff are very positive and motivated with sincere efforts to improving the health and well-being of clients. GMHC staff is well organized with strong commitments through team work and coordination outside as well as within the organization.

In addition, GMHC has great support from the Bozeman community. GMHC receives support from Deaconess Hospital (Hospital) and law enforcement for crisis stabilization services. Staff from GMHC sits on various community committees and boards, including the Greater Gallatin Homeless Access Solutions Committee. Many law enforcement staff has completed Crisis Intervention Training. GMHC participates in the county's jail diversion program, VIRGIL Project, and provides mental health services in the detention facility. This collaboration with community stakeholders is perhaps the greatest strength of GMHC and helps address and lessen stigma associated with persons with mental illness.

Organizational Planning and Quality Improvement

Gallatin Valley Mental Health GMHC (GMHC) creates a strategic plan and work plan annually. The work plan is updated and reviewed at least quarterly gauge progress. The process uses information gathered from satisfaction surveys completed yearly by both staff and clients. The operational plan is the work plan for the year. The goals and objectives are assigned to specific programs within GMHC. The goals and objectives include staff training goals, general operations tasks, and programming needs. Objectives are assigned to specific individuals within each program.

Individual programs within GMHC have their own work plans that flow directly from the Organization's strategic plan. Some of the work plans contained language that was too vague or general to be used as an effective tool for the implementation of measurable goals, and most of the work plans could benefit from having specific timeframes set for achieving goals and objectives, with specific staff responsibilities to achieve goals and objectives.

GMHC uses a process of continuous quality improvement to evaluate and improve its activities related to inpatient and outpatient services. Designated staff is accountable and responsible for the process. The Person Outcome Management System (P-COMS) is used to measure mental health outcomes for individuals served. Before each session, the client completes a brief questionnaire as measurement of current status. At the end of the session, the client completes the questionnaire to indicate progress and satisfaction with the session. This creates a positive feedback loop by the client which develops trust and value in the client's perspective of the relationship with GMHC staff. Information obtained is used to determine therapeutic approach and to ensure individuals served are realizing treatment progress. This process enables the staff and client to discuss ways to improve treatment, or if treatment is no longer necessary. P-COMS is a client-driven process that is part of the recovery-oriented approach of GMHC.

The quality assurance process and staff training policies are found in GMHC policy and procedures, the professional licensing is current, clinical staff meet required certification standards.

GMHC makes use of an intern program through Montana State University (MSU). Two intern slots are assigned to the outpatient program each year. Intern's work 10-15 hours per week and are supervised weekly by therapists at GMHC and a supervising instructor at MSU. The intern program has resulted in a number of quality staff being recruited after internship completion. Similar intern programs would be valuable to other WMMHC programs.

Satisfaction surveys that use a 1 to 5 point scale are administered to clients/staff and not necessarily to family/guardians. Current results show that most clients strongly agree and are generally very satisfied with the services provided by GMHC. Most surveys are obtained from clients and staff with very little input from family members. Therefore, it is difficult to determine how family/guardians feel about GMHC services. Because family/guardian involvement and collaboration is a critical component of recovery oriented system of care, GMHC should consider additional opportunities to engage family/guardians in providing formal feedback. Clients have opportunities to comment on their satisfaction with their services and can also use the grievance procedure if they feel their rights have been violated. Quality Assurance tracks the following components to assess client satisfaction:

- Clinical Peer Review
- Administrative Review
- Client Satisfaction Review
- Annual Quality Improvement Reports
- Professional Standards Review Committee

Suggestion:

Update program work plans so they are specific and measurable, with designated staff and completion dates.

Rights, Responsibilities and Safety

Client rights and responsibilities are explained during the intake process, where information is provided verbally and in writing. The client signs the statement of rights/responsibilities document, and it is filed in the client's electronic record. This information is discussed and reviewed during therapy sessions. Information about GMHC's grievance policy is given to all individuals and complies with GMHC policy and procedures. The grievance form does not mention the BOV or the opportunity for assistance from an advocacy group external to WMMHC.

Clients receive written information about the Mental Disabilities Board of Visitors (BOV), including contact information and the role the BOV can play to assist individuals during GMHC's grievance process. Advocacy services are posted in appropriate places within the facility; however no mention of advocacy services appears within the packet of intake information sample provided to the BOV site inspection team.

Staff is well trained in the process to protect clients from abuse and neglect, and staff interviewed easily described this process to BOV. This is a standard policy of Western Montana Mental Health (WMMHC) which is followed by all the satellite offices. The policy covers mandatory reporting requirements for children and people with disabilities, as well as specifically covering the process for reporting found within the mental health statutes. The policy is well written and clear. Historically GMHC has met the statutory requirements under 53-21-107, Montana Code Annotated. GMHC uses the Employee Assistance Program services to support staff as needed. Hope House provides individual access to staff of specific gender as requested to the greatest degree possible and is usually able to comply with this standard. Staff interviewed remarked that recent training to address cultural needs of individuals who identify with alternative lifestyles has been useful.

The facility has policies and procedures in place for the use of seclusion/isolation in the safe areas of the emergency detention side of Hope House. This is the only area where seclusion beds were noted.

Individual, Family Members/Guardian Participation

Interviewed staff said that family /guardians were identified and included in the individual treatment plan, with client permission, which included appropriate documentation, signatures, and written service delivery activities. Even with this documentation and efforts to involve supportive family members, staff reported that often individuals did not receive the kinds of family support they needed to be successful. Often family was not available or their support was not appropriate for helping meet client needs. Family support is critical for clients and developing parameters for communication with family must occur so the client and family know their roles in developing a successful treatment plan. The staff is very proactive in ensuring that all clients have the best possible supportive resources available. All persons served are given resource materials regarding maintaining positive communications and supportive involvement in the client's treatment and/or recovery process.

Staff is very clear about only disclosing information that was in compliance with and allowable by the HIPAA Policy. With consent, information pertaining to an individual's diagnosis, options for treatment, medication, and possible prognoses were shared with family/guardians. It was stated that releases were only valid for six months. Staff works with clients to help them understand the kinds of circumstances where GMHC must release protected health information.

All staff indicated they take advantage of the opportunities to involve family/guardians in the operation of services. Whenever possible, family/guardians are encouraged to provide feedback regarding the quality and effectiveness of services provided by GMHC through group discussion, formal and informal support, surveys, and "one-on-one" inquiries. During the site inspection, one person said that that minimal participation is the "norm" by family members even though participation is highly encouraged by staff and opportunities are made available for family/guardians participation at all levels of service.

During the site inspection interviews, no one indicated that family/guardians participate in advisory groups, public meetings, or peer/staff education, and /or training. Although some educational opportunities may be offered, they are not mandatory for clients and families as part of a formal treatment program.

Cultural Effectiveness

GMHC utilizes "Program Specific Training and Clinical Orientation" to comply with Administrative Rules Montana (ARM) mandatory training requirements, indicating the type of training, by whom, and the time frame in which training is administered. Cultural sensitivity training is mandatory for all GMHC staff within 30 days of hire. There are also "Training Curriculum Descriptions" in which ethics, legal responsibilities, and cultural sensitivity are described. The training description states "that the staff will learn what cultural competency means, and what it takes to develop and nurture this life-long skill."

GMHC staff demonstrated a very open and honest awareness of their individual knowledge about cultural, ethnic, social, historical, military service, and spiritual issues relevant to the mental health treatment of the people served. Staff demonstrated their "sensitivity" by always inquiring with the clients about their backgrounds. It appears that there is very little or no contact with the American Indian population in Bozeman that may need or require mental health and/or substance abuse services. There was no mention of any American Indian staff working for GMHC although there are workers with different ethnic backgrounds.

It was mentioned that the Montana State University has a fairly large American Indian student presence but GMHC has little or no contact with that population. During the site inspection, interviewed staff said that most of the cultural diversity in the population was related to socioeconomic classes. During the site inspection interview, one staff member said there was a "coulee" in east Bozeman where most American Indians, live either due to homelessness or are transient.

GMHC has a very comprehensive power point concerning Cultural Sensitivity and Diversity; however, it lacks any indication of specific applicable laws related to American Indians and their special status as sovereign nations. The specific laws related to education, health, civil rights, religious freedom, child welfare, and other acts of congress and/or the state relating to their unique government to government status under treaties established in the 1800's should be included. Also, there does not appear to be any specific training about the unique approach one must have in working with American Indians that have mental and substance abuse issues. There is no indication of a recognized expert who could help them in the various aspects of cultural diversity, including American Indian clients.

One staff member didn't seem to understand the cultural "norm" of an Indian client (which is somewhat rare) and the client's priorities based on his own culture. This is not a criticism but just an observation in which good intentions were demonstrated by the clinician who failed to consider appropriate cultural issues.

Overall it appeared that the teaching of Cultural Effectiveness is done by experts in all areas with the exception of American Indian considerations and awareness. This probably isn't a priority due to the very few American Indians that are clients (less than 4 per year - maybe); however, learning about this culture may help understand the diverse richness of other cultures. All clinical staff interviewed during the site inspection was open minded, welcomed improvements and education opportunities. This was in addition to their required curriculum concerning other cultural sensitivity training. More importantly most GMHC staff stated or used the term "cultural effectiveness" which indicated their ability to apply their knowledge in a culturally effective manner.

The GMHC staff demonstrated and spoke of the importance of culturally diverse issues based on a "strength based recovery model" versus a "clinical approach" to services. Statements by the staff indicated over and over that their services were "holistic, strength and recovery based, relational and team oriented, with a client support system of care." A list of community resources has been developed with 46 service providers listed and new providers are added continually. Unfortunately there were no American Indian Resources listed in the Community Resource listing. This is probably due to the location of the reservations in Montana—none of which are located near the Bozeman area. Another possible reason that these resources were not listed is because of the lack of American Indian clientele served by GMHC. Regardless, there is a variety of resources at the Montana State University in Bozeman that include American Indian personnel and resources that could benefit GMHC and should be explored. Meetings with stakeholders and partners take place several times a month. Treatment plans include community resources that are relevant in meeting the needs of the client. One client interviewed said, "The resources at GMHC are better than most- they have a warming center."

It didn't appear that there was a specific plan for recruitment, retention, and promotion of staff from cultural/racial/ethnic backgrounds specific to military or American Indian People. However, the overall staff tended to represent the diverse needs of the community of Bozeman.

Administrative staff has a “no tolerance” approach to staff that might demonstrate issues that may arise regarding prejudice and/or misunderstanding towards others, including military service members and American Indian people. It was indicated that there has been very little or no issues regarding this concern which can be attributed to effective training and staff monitoring. Staff interviewed said that team meetings have been helpful in preventing any ongoing issues regarding individual bias.

Staff Competence, Training, Supervision, and Relationships with Residents

Staff interviewed reported that each new employee is required to attend a new employee orientation training not to exceed 30 days, which includes Mandt⁴ training, and they work several days of supervised shifts. Training records are in the manual and newly hired staff keeps training progress sheets. The staff interviewed was well educated and most had advanced degrees. They report that they pursue continuing education opportunities. Professional staff and supervisors seem accessible and aware of all the appropriate technologies that are available.

All staff is required to record training and in-service hours as staff education on the weekly time sheet. Additionally, program managers are responsible for ensuring that all training is entered on the GMHC portal, which is available for inspection by supervisors, during audits or for others with a need to know. Individual staff training needs identified through the Annual Performance Evaluation will be highlighted on the evaluation form and staff will be required to address any training deficiency identified through additional training and/or supervision.

BOV site inspectors observed all staff was of the highest quality and demonstrated respect, empathy, and calmness to clients. The staff clearly and proactively explained rules and how important it is to have constructive engagements with all individuals in the units and how to resolve conflicts in this environment. Expectations were clearly defined and modeled. Interactions were meaningful and a sense of pride was evident. Supervisors have a close relationship with staff and model for them a positive recovery-orientated manner that is evident throughout the facility.

Clients interviewed report that their experiences with facility staff are consistent, prompt, positive, and respectful. The entire atmosphere of the facility was clean, calm, professional, and dignified. Staff was present and available in all of the facility settings.

Treatment and Support

Treatment Planning:

Treatment plans are initiated during the clinical intake assessment. The clinician then makes referrals to other services as indicated, including medication management, outpatient services, and case management. Treatment plans are reviewed every 90 days, using the electronic records management (ERM) program. Electronic records are used agency wide in all communities served by WMMHC. This use of a single platform for client records is useful for continuity of treatment and support as clients move from community to community in the WMMHC region. The treatment plans reviewed appeared complete and comprehensive.

Upon arrival at Hope House a registered nurse conducts an interview and physical examination as soon as the client is able to participate. Some clients enter Hope House from the Emergency Room (ER) at Deaconess Hospital, and have already received a medical examination, including lab tests. GMHC has immediate access to the Hospital's ER records, lab results, and examination notes. This allows for immediate treatment and support when clients enter the inpatient services provided at Hope House. The Mental Health Nurse Practitioner (MHNP) is on-site at the Hope House, which allows for full integrated care.

Housing:

Housing for clients is an area of significant challenge for the GMHC as Bozeman has the highest housing costs in the state. Although few clients are homeless, it poses a significant difficulty for them as affordable housing is very limited. The Drop- In Center provides a haven for individuals during the daytime hours; a shelter provides a safe overnight location during bad weather. The Warming Shelter closed on March 31, as it is only open during the colder winter months. Staff noted that GMHC has provided access to campsites and tents for individuals during the summer months. GMHC does have permanent, safe, affordable, quality supported housing on the GMHC campus but access is quite limited. This community has significant housing shortages.

Case managers expressed frustration in the lack of housing for individuals served at the GMHC, although when housing is available, the case managers will advocate and communicate with landlords to resolve problems to ensure clients have options for quality housing. Bozeman does not have mental health group homes per se. One of the goals stated in the strategic/operational plan is to recruit people in the community who can provide housing/placements for those clients who otherwise may not be able to live completely independently. Case managers note that nearly half of the clients served by case management services are homeless. The GMHC issues cell phones to clients in order to help alleviate communication difficulties. BOV site inspectors were concerned about the problem of homelessness among the clients GMHC serves, and would advocate for more housing options within the entire WMMHC region.

Crisis Stabilization:

GMHC has a strong relationship with other community providers and agencies. Deaconess Hospital, for example, supports Hope House crisis stabilizations beds, and individuals in need of this service can be directly admitted to Hope House without an assessment in the ER. The majority of law enforcement in Bozeman is trained in Crisis Intervention Training (CIT) which allows for better and safer interventions

with persons in crisis. As a result, the program director stated that admissions to Montana State Hospital have been reduced by 50%. In addition to Hope House, the Help Line in Bozeman provides a 24-hour crisis line, and the Crisis Response Team is available 24 hours per day, 7 days per week.

Trauma Informed Care:

Assessing trauma history is part of the initial intake assessment, and is included in the treatment plan if the client requests addressing trauma as a goal. Few training opportunities for staff are offered in this area; there is no training on universal trauma precautions. Training includes suicidality and de-escalation training. Intakes are only an hour long, so it is hard to include a thorough trauma-informed assessment. Two therapists in the Bozeman office are trained in Eye Movement Desensitization and Reprocessing (EMDR), which is an evidence-based practice to help clients address trauma.

Medications:

Medications prescribed are evidence-based and reflects internationally accepted medical standards. Medication is prescribed, stored, transported, administered, and reviewed by the MHNP and RN staff. Medications are locked in a secure area that is only accessible by designated staff.

The MHNP uses PRN (medication as required) as a part of a documented continuum of strategies for safely alleviating distress or risk at the Hope House. Individuals treated in the outpatient program are able to seek opinions and treatment from other providers at GMHC. Medical staff at the inpatient and outpatient programs confers with other service providers to ensure good continuity of services for clients. Access to the psychiatrist or MHNP can take 4-6 weeks. Appointments are 30 minutes long with 2 emergency slots available for clients experiencing adverse/side effects each day. GMHC is addressing this lengthy wait by adding a psychiatrist and 3 new mental health nurse practitioners. The goal is to reduce the waiting time to 2-3 weeks. Clients who present at the Hope House in crisis have immediate access to a prescriber.

When medications are prescribed or changed, information about adverse reactions or side effects is provided and discussed with the client. The MHNP monitors clients according to the consensus guidelines of the American Diabetes Association and the American Psychiatric Association.

The GMHC has a policy/procedure in place for documenting and reporting medication errors. Nursing staff interviewed was conversant with the policy and process, and reported that the process works well, even though medication errors are rare. The GMHC provided the policy/procedure for dispensing medication samples. Samples are used; the use is clearly documented and follows policy.

Unused medications are disposed of properly using the same protocols used by the Hospital. The process involves disposing of medications in Sharps Containers that are collected by the Hospital.

Access and Entry

Referrals to GMHC come from a variety of sources, including private practitioners, hospitals, the detention center, law enforcement, self-referral, and Montana State Hospital, to name a few. It appears there have been some problems with discharges from Montana State Hospital. One case manager described these discharges as “inconsistent”, with “sporadic communication” and sometimes “a surprise”. The program director at Hope House has been designated as primary contact for any discharge planning from Montana State Hospital. GMHC staff frequently applies for and use “Goal 189” monies to help establish mental health services.

Continuity of Services through Transitions

GMHC has excellent follow-up or aftercare plans with all clients and other members of their supportive team. Staff indicated that it is critical that case planning from one service to another is incorporated into their treatment planning to ensure “seamless” services and the continuation of effective services.

Children who are enrolled in Comprehensive School and Community Treatment program are being directed to mental health services. In-service training with high school staff helps with the transition piece in the Individual Education Plan to help children/adolescents receive mental health services. When a client transfers services from one Primary Care Coordinator to another or from one sub-facility to another or when the client moves from Children's Services to Adult Services, a note is written by the prior Primary Care Coordinator and entered into the Clinical Record. The note may include:

- Reason for Transfer
- Summary of services
- Progress on treatment goals
- Impact of services
- Recommendations for further treatment

Individual treatment goals are regularly reviewed to determine whether the client is successfully meeting treatment goals and is ready for discharge from either individual programs or GMHC in general. Each service offered by GMHC has an established admission and discharge criteria. The role of the Primary Care Coordinator is to review progress in treatment and determine when discharge criteria are met. Each Adult Individual Treatment Plan/Review will identify discharge planning activity and goals for the client. A client may also be terminated once they have moved or there has been no contact with the client for more than 90 days.

Services

The Drop-In Center: GMHC is welcoming and attractive. Clients have access to a kitchen to prepare meals, telephone, computers and Wi-Fi. A washer and dryer are available. Groups meet every day, twice a day and this informal level of treatment appears adequate for some of the clients who use GMHC. The drop-in center had approximate 6 visitors on the day we visited. Peer support staff is on

site. Staff reports that the clientele is generally mostly men, although staff has seen more women lately. Occasionally families will come together at the Drop-In Center. Staff reports that many Native Americans and veterans attend the support groups offered each day.

Drop-In Center staff reports that they received basic safety training, including the use of an emergency telephone button to summon staff in the event staff needs help. Staff impression is that clients go from the Warming Center where they sleep, to the Salvation Army where breakfast is offered, to the Drop-In Center for lunch, and back downtown to the library or other places for the afternoon and evening. Staff stated that having more than one trained staff person at a time at the Drop-In Center would allow for greater safety and ability to respond to client's needs.

The Outpatient Program: The lobby is very welcoming, is quiet, and the reception staff observes protocols for privacy. Front desk and reception staff is trained to observe individuals who appear at the lobby to recognize possible triggers for trauma or possible aggressive actions. Two staff members are always at the front desk for security reasons. All clients served receive a reminder call the day before their scheduled appointment. This process has reduced 'no shows' for appointments, although staff reports that failure to appear for appointments is still a concern. One staff at the reception desk is responsible for sending record releases to other providers. This single point of request/access ensures that information is requested and received so each client's file has complete information. When family/guardians call to request information about clients served, the reception desk can access release of information forms through the EMR system immediately to know whether information can be shared. Support staff is responsible for many of the general office operations including processing paperwork, conducting new employee orientation, managing time and attendance, coordinating office training, and office ordering. The office has a staff of seven staff including 3 support staff, 3 billings clerks, and 1 staff doing deposits and other bookkeeping. The support staff manager conducts the safety committee and the training committee which meets quarterly to update material. She reports that fire drills are conducted quarterly and that CPI is reviewed quarterly.

Hope House: The crisis stabilization program is a model for both crisis services and emergency detention services. Members of the Montana Legislature, law enforcement, and community leaders from other communities visit regularly to look for ways to replicate GMHC services in other communities across the state. The collaboration between the county commissioners, county law enforcement, the Hospital, and other services in Bozeman has created a program that is efficient and effective. The communication between the Hospital, law enforcement, and the GMHC is also a model other communities are trying to duplicate. A representative from law enforcement attends the monthly Hope House meetings.

Hope House includes 8 voluntary and 2 involuntary beds. Most clients are sent to Hope House for assessment. They may leave after assessment, be checked in for services or transported to the Hospital for medical care.

Hope House offers a wide variety of resources, including such things as access to clergy and essential oils. Clients stay an average of 3-5 days with follow-up at 2 days and 1 week post discharge. Staff conducts three group-therapy sessions each day. Hope House staff is responsible for providing Crisis Intervention Training to local and regional law enforcement. Currently there are 3 full-time APRNs offering psychiatric services at Hope House. A psychiatrist contracts to provide telemedicine consultations when necessary.

Partners for Change Outcome Measurement System (P-COMS): This measurement tool is very impressive. This system is used at all offices in the WMMHC region. The use of the outcome rating scale and the session rating scale to evaluate the services from the client's perspective can be used for quality assurance, operational and strategic planning, and establishing annual work plan goals. In addition, the information collected appeared to be useful for therapists to evaluate the progress each client is making. Clients are active participants in evaluating their progress. Some staff interviewed was reserved in their judgment of the value of the P-COMS data and usefulness, but others were vocal supporters of its value.

Vocational Specialist - Supported Employment: This important program uses Dartmouth's Individual Placement and Support model of supported employment. The vocational specialist program manager has a Bachelor of Science degree in physical sciences. The program manager reports that clients are referred by the case management team. There are currently two full-time vocational specialists and one program manager, who reports that a huge diversity of jobs is found for clients. Each caseload is limited to 20 with overflow referrals put on a waiting list. The program manager reported that she and her coworkers have received their Dartmouth training in person and that ongoing training was available online. The staff recently attended 'Safe Zone' training at MSU which covered topics related to serving the LGBT population. The program manager felt the training was instructive and relevant to their clients. The program manager reported seeing very few veterans but was aware that 2 were on the waiting list.

Case Management: This very important service is provided to many GMHC clients. The clinician who completes the initial intake assessment makes referrals to case management services. The case manager develops the treatment plans for all clients receiving this service. Each caseload ranges from 20 – 30 clients. One case manager estimated that 90% of clients on his caseload are on probation or parole. Another case manager provides payee services and "manages" the supported housing apartments on the GMHC campus. Hope House has its own case manager.

Case manager training includes the initial orientation for all new employees, 16 – 20 hours of training videos that address diagnoses and other mental health issues, and observing colleagues. The case managers feel they are well supervised and feel comfortable seeking support whenever needed. New case managers meet with the supervisor weekly, and experienced case managers receive supervision monthly. Case managers attend weekly meetings.

All interviewed case managers identified homelessness as their primary focus and concern. They work closely landlords and housing assistance programs. Many of the clients receiving case management are homeless. Two of the interviewed case managers participate in the Greater Gallatin Homeless Access Solutions committee to address the homeless problem in Gallatin County.

Case managers assist with job support, obtaining benefits, housing, and other needed services. Case managers attempt to engage family /guardians, especially if that involvement is in the client's best interests. Case managers will refer family/guardians to NAMI.

Supported Housing: There are two supported housing facilities on GMHC campus providing 10 studio apartments. The studio apartments are roomy, clean, and the floorplan is functional. There are lots of windows providing natural light. Residents of the apartments receive services from GMHC, and all have case managers. The residents' rent is affordable. Each building is designed differently; one building has an area for visiting and a washer and dryer for all supported living residents. GMHC recognizes that homelessness is a primary concerns for many clients, and provides supported housing options to help address homelessness and to increase independence. GMHC does not manage group homes, as these may increase dependence on providers. WMMHC as an agency would do well to address homelessness in the region and consider developing and building supported living apartments in the communities where services are offered.

Recommendations:

- 1) Provide training on "Universal Trauma Precautions" according to SAMHSA guidelines. Refer to "Trauma Informed Care in Behavioral Health Services", SAMHSA Treatment Improvement Protocol #57.**
 - a. GMHC will include training specific to trauma as part of annual training staff receives.**

- 2) **Initiate contact with Montana State University to learn more about American Indian resources that are available to clients served by GMHC.**
 - a. **GMHC meets quarterly with Montana State University leadership. GMHC also hosts dozens of nursing interns every year, 4-5 under-graduate interns every year, and 2-3 graduate interns. GMHC feels very good about current relationship with MSU and will continue to expand and strengthen that relationship. Specifically, GMHC will reach out to MSU to form new partnerships for cultural awareness and competency to include American Indians.**

- 3) **The agency as a whole needs to address the development of a Cultural Effectiveness Plan, increase training and awareness of cultural, ethnic, social, historical, military services, spirituality and gender. Refer to SAMHSA manual “Improving Cultural Competence” Treatment Improvement Protocol 59.**
 - a. **See 2a. GMHC continually reviews training program and gaps and needs for trainings. GMHC will commit to strengthening our cultural competency through increasing relationship with MSU, utilizing staff, and also pulling from best practices to include SAMHSA.**

- 4) **Ensure staff are trained as part of orientation in the basic definitions and elements of abuse and neglect as those definitions and elements apply to them under the Mental Health statutes. This training might be included in the current session titled: “Rights of Consumers and Grievance Procedure”.**
 - a. **Staffs are all trained as part of new hire training and receive information on client grievance and rights as well as Board of Visitors, NAMI, Disability Rights, and Mental Health Ombudsman. Staff all sign off on a new hire orientation check list and review a power point with this information. GMHC believes this is very important to client care and that is why we have created specific trainings and power points surrounding rights and responsibilities.**

- 5) **Include information about the Mental Disabilities Board of Visitors, the Mental Health Ombudsman, and Disability Rights Montana in the informational packet given to the clients upon intake, and on the grievance form that the client signs.**
 - a. **GMHC will work with WMMHC as a whole to make sure that contact information is included in the grievance form.**